Supplemental Nutrition Program for Women, Infants and Children
Montana Application for Local Programs

I. Instructions

A. It is suggested the applicant contact the State Program Coordinator before completing this application. Early contact between the applicant and the State Agency will help minimize problems.

B. Please answer all questions completely.

C. Use the most current data available.

II. Evaluation Criteria

The following criteria, but not limited to, will be taken into consideration:

- Is there public health office support/coordination in the proposed service area.
- Are there enough participants in the area to support a clinic and is there potential for growth.
- Is there a registered dietitian or nutritionist available to work with high risk participants.
- Is the proposed clinic a public or private nonprofit health agency which provides ongoing, routine pediatric and obstetric care and administrative services. If not, is such an agency within the same service area for referral.
- Are there retail outlets in the service area where food instruments can be cashed.
- Does the funding per participant fit within the structure of the funding formula. If not, is in-kind funding available.
- How will the addition of a clinic affect the operation of the WIC computer system (i.e. processing time, upload/download, reporting, hard disk space, etc.).
- What equipment will need to be purchased in order to begin operation of a new clinic (i.e. computer, scales, measure/stature boards, hemocue, office furniture, storage cabinets, etc.). As well, what costs are associated with this and is there existing equipment that could be shared with another public health agency.
- How will the addition of a clinic affect the workload of the state office staff (i.e. computer and competency based training, monitoring, technical assistance, etc.).
- Are there sufficient funds to operate an additional clinic within the existing federal grant.

III. Applicant Information

A. Applicant Agency Name: _____

B. Address: _____

C. Telephone: _____

D. Name, title and address of responsible official: _____

_____

E. Type of Agency:

- ☐ Public
- ☐ Private, Non-profit
- ☐ IRS Tax Exempt #_____
- ☐ IRS application pending (Date submitted ____/____/____)
- ☐ Tribal
- ☐ Other. Describe: _____

_____

IV. Health Services

A. Is there currently a Well-child service in your community? If yes, describe (use additional sheets if needed):

If no, describe your plans to provide this service (use additional sheets if needed):

B. Do you currently have a Prenatal Education program? If yes, describe (use additional sheets if needed):

C. Is breastfeeding education part of the Prenatal Education program?

1. Is there a linkage with the hospital to provide support for the woman who chooses to breastfeed her infant? Describe. Include the number of pregnant women served by the hospital in the last 12 months. (Use additional sheets if needed):

2. If no linkage exists, describe whether other community health agencies provide this service. (Use additional sheets if needed):

D. Describe your plans to refer Program participants to a public agency or private provider for follow-up on identified health problems, including the procedure for feedback from the public or private provider. (Use additional sheets if needed):

V. Nutrition Services

A. Provide the name of the individual who will act as Competent Professional Authority, CPA. A CPA is an individual on the staff of the local agency authorized to determine an applicant eligible for participation, determine nutritional risk and prescribe supplemental foods. The only persons

who may be authorized to serve as a CPA are: Physicians, Nutritionists, Dietitians, Registered Nurses, Certified Physician's Assistants, Home Economists, or a state or local medically trained health official:

B. Provide the qualifications (education, licensure, etc.) of the person named above. (Use additional sheets if needed):

C. What do you anticipate necessary FTE to be? For example, CPA, Aide, office manager, etc. List position title and anticipated FTE.

VI. Socio-Economic/Vital Statistics

A. What will be your service area (county or reservation):_____

_____

B. What is the service area population?_____

C. What is the service area racial/ethnic composition?

1. White _____%
2. Black _____%
3. Hispanic _____%
4. American Indian _____%
5. Asian or Pacific Islander _____%

D. What is the median family income in your service area ?_____

_____

E. Which of the following programs are available in your service area. Provide the most current caseload figure. List a contact person who will be used for referral for each program.

1. Pathways/FAIM:_____
2. Supplemental Nutrition Assistance Program (SNAP):_____
3. Medicaid:_____

4. MCH Home Visiting:_____

F. What is the incidence of the following for your service area:

1. Premature Infants_____

2. Low Birth Weight Infants_____

3. Teen Pregnancy_____

4. Other risks you have identified (describe):_____

_____

_____

VII. Financial Management

A. Provide a projected 12 month budget for the proposed WIC activities. This should consist of salaries, benefits and operating expenses (include and list any new equipment which will need to be purchased; ie, weighing and measuring devices).

B. Provide a copy of the most recent financial audit of your agency.

C. List who will provide expenditure reporting? (i.e. WIC Staff, Clerk & Recorder, etc.)

VIII. WIC Caseload	Current	Projected
A. Women	_____	
B. Infants	_____	
C. Children	_____	

Any descriptions of the characteristics of the projected caseload, such as number of pregnant teens, older pregnant women, etc., are very helpful.

IX. Physical Location

Describe the location where participants will be served. Be specific (i.e. Health Department, City-County Building, Hospital, etc.). Describe office space, size of space, location of phone and power outlets, available waiting area, etc. A drawing of the space is helpful.

Describe what secure storage is available for food instruments, computer equipment, participant files, etc.

X. Retailer Services

List name and location of retail stores which are currently authorized or under contract to redeem WIC food instruments; or ones which may be willing to enter into contract (use additional sheets if needed).

XI. Begin Date

A. When do you anticipate being ready to open a WIC clinic?

B. How many days per month and hours per day do you anticipate offering WIC services?

The applicant agrees that WIC Program benefits will be provided to eligible participants without discrimination on the basis of race, color, national origin, age, disability or sex.

The applicant further agrees and assures that if selected, it will comply with the WIC Program Federal Regulations and State Policies and Procedures for WIC Program operations.

The information contained in this application for a WIC Program is true and accurate to the best of my knowledge.

_____ _____

Date Signature of Local Official with Authority to Implement WIC Program